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THE YOUNG MOTHERS EDUCATIONAL DEVELOPMENT PROGRAM. TWO PIECES. (TITLE SUPPLIED).

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THIS REPORT DESCRIBES THE MEDICAL, EDUCATIONAL, SOCIAL, AND PSYCHOLOGICAL SERVICES OF A PROGRAM FOR DISADVANTAGED UNWED PREGNANT TEENAGERS IN SYRACUSE. THE PROGRAM, WHICH HAS BEEN IN OPERATION FOR A YEAR, ATTEMPTS (1) TO PROVIDE A NEARLY TUTORIAL INSTRUCTIONAL PROGRAM, (2) TO ESTABLISH INDIVIDUAL DOCTOR-PATIENT RELATIONSHIPS, (3) TO TEACH THE GIRLS METHODS OF INFANT CARE, AND (4) TO FACILITATE THE INFANT'S ADOPTION. ALTHOUGH NO FORMAL EVALUATION HAS BEEN MADE, THE RESULTS THUS FAR INDICATE THAT THE PROGRAM HAS BEEN SUCCESSFUL. IN ADDITON TO THE DESCRIPTION OF THE PROGRAM, THE REPORT CONTAINS A BRIEF DISCUSSION OF THE PROBLEMS OF THE INCREASING RATE OF ILLEGITIMATE TEENAGE PREGNANCY--FREQUENT ABSENCE OF PRENATAL CARE, THE TERMINATION OF THE GIRL'S EDUCATION, AND THE DIFFICULTIES OF THE ADOPTION OF THE CHILD. (LB)

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PROBLEMS OF THE PREGNANT SCHOOLGIRL

- AN ATTEMPTED SOLUTION

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The problem of the teenage pregnancy has been receiving a great deal of thought, both in the United States and abroad. The absolute number of teenage marriages has been steadily rising in this country, and the percentage of marriages occurring between teenagers has been increasing at a proportionally faster rate than marriages in general among the remainder of the population. (Population Reference Bureau, 1962) In 1959, in the United States, 39% of all brides were teenagers compared with 33% only ten years earlier. Along with the rise in teenage marriages are the grim reminders of multiple problems. The highest divorce rate occurs among couples married in their teens, being 3-4 times higher than those married at a later date. (Rankin, 1964) Further, as the number of teenage marriages has increased, there has been a progressively rising number of babies born to teenage mothers. Whereas in 1950 27% of first babies were born to mothers in their teens, the proportion had increased to 36% by 1959. (Wallace, 1965)

One of the major problems of teenage marriage is the association with premarital pregnancy. (Wallace, 1965) In California, it would appear that approximately 50% of marriages between two high school students involve an already conceived

pregnancy. (Landis, 1964) In Maryland, pregnancy looms as the number 1 condition resulting in teenagers leaving school prior to graduation. (Stine, 1964) Pregnancy is the cause of teenagers leaving school more than twice as often as all other medical and physical conditions put together. And even more frequent than the pregnancy being related to a hastily conceived or early marriage, is the pregnancy which is associated with an out-of-wedlock condition with the accompanying social pressures and condemnation which such a condition causes.

The problem of out-of-wedlock pregnancy in general has also been receiving greater attention. In the United States, 1938 there were 87,900 pregnancies reported to unwed mothers, comprising 3.6% of the total number of live births. By 1960, the figure had reached approximately 225,000 equalling 5.2% of that year's births. (Vincent, 1961) In England, in 1961, one child out of 20 was born illegitimately, one in eight was conceived outside of marriage, and one in four mothers conceived their firstborn offspring before marriage. (Editorial, Lancet, 1961) In New York City, in 1946, 3% of all pregnancies were illegitimate; by 1959 this figure had reached 8% and by 1963, 11%. (Rashbaum, 1963) Between 1940 and 1957, 2.5 million surviving illegitimate children were born in the United States. (Vincent, 1961) Of this figure, approximately 40% were born to white mothers, and 60% were born to non-white mothers. This figure, however,

is extremely misleading, because it in no way can take into account the over one million abortions performed illegally in the United States per year, of which the overwhelming majority are performed upon white woman. (Kinsey, 1958) As has been indicated, a high percentage of out-of-wedlock pregnancies occur in females under the age of 20. (Vincent, 1961) 2.1% of all out-of-wedlock pregnancies occur under the age of 15; 88.7% of all pregnancies occurring to females under the age of 15 are conceived out-of-wedlock. (Pakter, 1961a)

From the medical, social, and educational points of view, the pregnant teenager represents a high risk individual. The issues are extremely complex. Medically, the unwed mother receives considerably less adequate care than her married peer; and as has been pointed out, the pregnant teenager often falls into this category. Perhaps the poor quality of prenatal care is associated with the same of out-of-wedlock pregnancy. Regardless of the circumstances, in New York City, for example, whereas 45 to 47% of married females received prenatal care in the first trimester, only 6.6% of out-of-wedlock females received similar care. Over 80% of married females received prenatal care by the end of the second trimester; only 50% of unwed mothers received such care. (Pakter, 1961a) As has been pointed out, educationally pregnancy has been the most frequent cause of drop out from school for 1 to 1½ years in the life of a teenager. Obviously,

for many, this results in the premature termination of school attendance. Socially, the problem is very difficult to evaluate. Most reports concerning the problem areas have come from homes for unwed mothers or agencies where patients are receiving extensive case work. Yet most teenage pregnancies are not cared for under such circumstances. First of all, maternity homes can care for only 20,000 patients annually. (Adams, 1963) This is less than 10% of the out-of-wedlock pregnancies. Further, patients attending such homes usually need to have some social mobility and financial backing since the average cost is $750 to $1000. Thus, the poor are usually excluded. In addition, only 12% of the females attending the homes are non-white in spite of the previously mentioned data which stated that 60% of all illegitimate births occur in the non-white population.

Almost all of the nursing homes encourage their patients to plan for adoption. Nationally, only 29% of out-of-wedlock pregnancies are adopted. 70% of white illegitimate pregnancies and 5% of non-white pregnancies terminate in adoption. (Adams, 1963) The lower figure for the non-white pregnancy is usually assumed to be related to cultural acceptability. However, a more reasonable understanding includes the reality of the non-adoptability of non-white children because of the unavailability of adoptive parents. Studies which have come from agencies where patients are receiving extensive care work also are biased in that the clients are often those with

considerable social mobility. Only one out of six out-of-wedlock mothers receive voluntary or public social service at the present time. (Adams, 1963)

Because of the major medical, educational, and social problems which teenage pregnancies present to the individual undergoing the pregnancy, to the baby resulting from the pregnancy, and to the community which has to deal with both the mother and the infant, it has seemed most appropriate to try and evolve a comprehensive interdisciplinary approach to the overall care of the teenage pregnant female. Such a program was set up in Syracuse and Onondaga County in the fall of 1965, with full function by late spring 1966. This program, known as the Y-MED Program (Young Mothers Educational Development) was an attempt to provide an unique medical, social, psychological and educational service for pregnant adolescents. The program, as established, was extremely broadly based, attempting to meet the needs of the individuals, and provide both the mother and the infant with maximum opportunity to lead useful, productive, and fulfilled lives within society. The program, in many concepts, is unique and differs from other services throughout the country. In the following paragraphs, an attempt will be made to explore the medical, educational, social and psychological problems facing the program at its inception, and the methods of solution utilized by the program in an attempt to overcome some of these problems.

MEDICAL PROGRAM

Modern Concept of Prenatal Care: Over the last decade there has been a gradual change in the concept of prenatal care. Impetus for this change has come, in part, from the realization that, at least in the United States, the curve for maternal and perinatal mortality has reached a straight line with little subsequent improvement. Although basic philosophies differ in various areas as to how to best approach this problem, much interest has turned to the identification of "high risk pregnancies", and then to direction of intensive care toward this group of patients. (Nesbitt, 1966) Wider prenatal screening for subclinical entities such as urinary tract infection, diabetes, congenital heart disease, genital cancer, hypothyroidism, anemia, viral disease, and genetic abnormalities has been added to previous routines for evaluation. Closer attention toward detection of venereal disease, with its recent increased prevalence, has been made mandatory. The role of drugs, genetics, habits and nutrition (with special attention to protein intake) has been stressed. Prenatal hospitalization for evaluation and control of special medical problems has assumed an increasingly important role. In addition to their basic medical value, such procedures have served to impress upon the patient the fact that the medical team is concerned about her pregnancy and maternal outcome and have helped to draw her into a greater self awareness and participation in solving her problems.

Earlier consultation with the pediatric team and involvement of other appropriate specialists have been found to have obvious advantages. In general, then, the increasing role of preventive medicine in obstetrics with a concentrated interdisciplinary approach to the high risk pregnancy group has been thebasis of the modern concept of prenatal care.

Is the Adolescent Unwed Pregnancy at High Risk?: Although the overwhelming majority of authors would answer that such pregnancies are at high risk, a review of the obstetric literature on this subject reveals a variety of opinions about what may be the predicted outcome of the young unwed pregnancy. The variability of results noted in studies of the young primigavida probably reflects the particular group of patients that the author studied. Stearn (1963) reported on 30 unwed primiparas under the age of 16 in England and found that there was some increased incidence of excessive weight gain, hypertension and toxemia but that in general the young mothers did well. He noted no prematurity, perinatal mortality, or need for abdominal delivery and found that a generally good mental attitude prevailed. In his discussion he quoted Caso (1950) who stated, "Pregnancy in young girls is not a cause for anxiety and the young mother shows an excellent capacity for maternity while the infants are of high vitality". Most American authors, however, disagree. Pakter, et al (1961b) studying a large group of adolescent pregnancies in New York City found that pregnancy complications were more frequent in the unmarried group.

She noted an increased incidence of toxemia, syphilis, prematurity, maternal mortality and infant mortality. Claman (1964), Aznor (1961), Polliakoff (1958), and Russio (1962) also stressed the increased incidence of toxemia in this group of patients. Hassan (1964) reported on 159 young primiparas between the ages of 12 and 15 compared to control groups of 22 year old primiparas and all patients delivered at two Chicago hospitals. He found that the study group had an increased incidence of excessive weight gain, prolonged labor, toxemia, cesarian section, cervical laceration, premature labor, and neonatal and perinatal mortality. Stine, (1964) reviewed records for Baltimore residents in 1961 and compared neonatal death rates and prematurity rates by age and race of the mother. His figures revealed a marked racial difference in all age groups with the non-white population contributing a significantly higher rate of pregnancy loss. *In addition, age alone, regardless of* race, seemed to play a significant factor with increased prematurity and neonatal death rates in the groups under 20 years old and especially in those under age 17. Battaglia (1963) reviewed all deliveries at the Johns Hopkins Hospital for the years 1939 to 1960 and compared mothers age 14 or less with control groups of 15 to 19 year old non-white mothers and the entire clinic. He found a significantly increased incidence of prematurity, perinatal mortality, toxemia and contracted pelvis in the group under age 14.

With few exceptions, it would appear, then, that most authors have found significant increases in the incidence of excessive weight gain, toxemia, feto-pelvic disproportion, prolonged labor, prematurity, perinatal loss and even maternal loss in the very young mother. Nutritional problems, anemia, hyperemesis, emotional problems, and lack of prenatal care are also frequently mentioned. In addition, the increased incidence of prematurity would appear to be of further significance in that, besides contributing to a large percentage of neonatal loss, extremely low birth weight infants who survive have been found to have a much higher incidence of mental subnormality and neurological deficit in later life. (Knoblock, 1962; Drillien, 1959)

It would appear, therefore, that the adolescent unwed pregnancy is definitely at risk. The reasons for this appear to be complex. Perhaps, in part, the difficulties can be related to the state of adolescence itself. Although the very ability to conceive in itself suggests a considerable degree of physiologic maturation, certainly the adolescent is in a state of flux physiologically and metabolically. Many of the organ systems, such as the thyroid gland and the pancreas, are already being stressed by the growth processes of adolescence and the effects of the additional stress of pregnancy are unknown. Further, adolescence is known to be a stage of life which is compounded by poor nutritional habits. In pregnancy where diet is of major importance, such

poor habits would assume even greater significance. Since out-of-wedlock pregnancy connotes social unacceptability, these patients have numerous social, emotional and economic problems, all of which can be expected to have dilatorious effects upon both body physiology and patient seeking and acceptance of medical care. In addition, since many of the patients who neither illegally abort themselves nor enter a nursing home are from the lower socioeconomic classes, there is the very real question of the adequacy of the metabolic and nutritional background prior to the pregnancy. In many, there is obviously a dietary deficiency of a long-standing duration. It would further appear that a significant percentage of such pregnant adolescent females have had difficulty in the past in relating to authority figures such as teachers and counselors. It would not be unlikely that such difficulties would continue in relationship to the medical authorities during a pregnancy. Finally, it is noteworthy that there generally exists a supervision gap in adolescent medicine in general.

With the previously mentioned concepts in mind, the medical program at Y-MED was established. The overall concept of this program was to provide an extremely broadly based service which would be unique in intensity and degree of personal attention. Girls were to be given care from the earliest possible point in pregnancy and this care was to continue throughout the pregnancy, labor, delivery, and first

postpartal period. In addition, a nursery was provided with a three-fold goal -- to give infant care in order to allow the mothers to return to school, to give good medical supervision and stimulation to the infants during the first year of life, thus giving the infants a better start in life, and to create an atmosphere which would allow the mothers to learn good techniques of child care, techniques which would, hopefully, carry over into subsequent years.

From the start, the traditional "clinic" concept was abandoned. While operating within the framework of a medical center program, the girls were treated completely as private patients. This was done both in an attempt to provide more effective medical care and to allow the patients to establish meaninful relationships with physicians - perhaps the first meaningful patient-physician relationships in their lives. Two senior residents were the permanent physicians in a group practice arrangement under the guidance of the medical directors. They met thegirls at the initial visit and followed them through the pregnancy, labor, delivery, and postpartal period. The girls were always given appointments to see their doctors with no long waits in an impersonal room. If an emergency developed, the patients could call the physicians through a 24-hour answering service. When labor insued, again the individual relationship prevailed. Their doctor was called; he would come to the hospital and follow the girls as any other private patients. Pediatric care was

arranged in a similar manner. An instructor in Pediatrics served as the program pediatrician. During the course of the pregnancy all of the girls individually met with him to discuss future pediatric needs. After delivery, he cared for the infants in the hospital, visiting with the mothers and informing them of progress. When the children returned to the nursery, he carefully supervised their care.

The obstetricians, pediatrician, and nurses conducted classes in small groups for the girls. These classes met an average of 3-4 times per week. The girls were taught basic facts about their bodies, pregnancy, delivery, and infant care. Questions were encouraged and frequently the discussions turned into seminars revolving around the girls' fears and anxieties. Twice weekly staff conferences were held. All members of the program, including physicians, nurses, educators, social workers, consultants, and members of appropriate agencies met to discuss each new patient and all patients with special problems. At these sessions, long-range goals for the girls could be discussed, and plans could be made and modified as seemed appropriate. In all matters the program was "girl oriented". Whatever was best for each individual girl was always the major consideration.

In this manner a medical program of a unique nature has been established to work in conjunction with the overall Y-MED Program. Care has been taken to appreciate the special problems of this group of high risk pregnant adolescents,

and their individuality is always the main consideration. Clinically, it would appear that the results should be extremely rewarding. Although a detailed review would be premature at this time because of the short duration of the program, up to the time of writing this article, in spite of multiple mild prenatal complications not a single perinatal mortality has been noted. In addition to the rewards of improved medical care and pregnancy outcome, it would further appear that this program will offer an opportunity for research in the poorly understood field of adolescent medicine and obstetrics with the possibility of correlating subsequent infant development with previous metabolic, social, and psychological pregnancy problems.

SOCIAL SERVICE DATA

Just as the preceding section identified the adolescent pregnant female as a high risk problem medically, from a social service point of view the pregnant adolescent, and especially the unwed adolescent, represents a high risk client with problems which are multiple in nature. In this section, an attempt will be made to discuss some of the general critical areas of social service need, especially as it pertains to pregnant girls within the lower socioeconomic groups. In addition, some of the early figures which are beginning to be available from the Y-MED project itself are to be presented.

Pregnant adolescents can be classified into two major categories - the pregnant adolescent who conceals pregnancy, and the adolescent who does not conceal pregnancy. Services and policies of agencies generally are geared to the adolescent concealing the pregnancy, continuing her education, and eventually returning to "normal activities". As has been previously mentioned, these girls are usually members of the middle class population who are financially able to leave home, enter another environment, and with some assurance plan upon adoption for their babies. Agency services for the pregnant adolescent not concealing her pregnancy have been limited to continued financial assistance and determination of paternity. Public school and even correctional institutions exclude girls who are pregnant. Prior to January 1, 1966, no agency in Onondaga County accepted girls for counselling services if these girls planned to keep their babies or if there was no plan for concealment. As a result, there is little or no information regarding the problems and backgrounds of this population. There has been a belief within the community at large that the population who do not conceal the pregnancy and keep their infants do so because of a cultural acceptance by their family and friends. This theory is especially accepted in regard to the adolescent non-white pregnant female. As has been previously mentioned, there are no valid statistics to support this theory. Rather, it would appear at least part of the willingness of the

females to keep and care for their babies is related to the unavailability of adoptive homes and agencies to provide major counselling. Since it has already been stated that the agencies provide counselling primarily for mothers who are planning to conceal and surrender their babies, and since lower socioeconomic girls, in general, and non-white girls, in particular, do not have the alternative of concealment and surrender, obviously the lower socioeconomic adolescents receive the least counselling and the least effective social service care in general. Further, on a nation wide level, even where programs have been set up to help the pregnant adolescent, most of the programs have concentrated upon the high achiever or girl with her first pregnancy. Where there has been a choice, the girl withthe best social prognosis has been accepted for care. Obviously the girl who needs the care most, and who represents the highest risk from a social service point of view, is most frequently excluded from programs on whatever level they exist. Therefore, in setting up the Y-WED Program, a major attempt has been made to exclude no adolescent girls who require services regardless of previous social complications or unacceptability.

During its first year of activity, (social service counselling preceded full medical and educational facilities by approximately six months) 125 pregnant adolescents were referred to the program from all sources. 36% were referred from the city and county school system; 19% were referred by

friends of the family or girl, 18% from medical clinics; 25% from other sources; and 2% were self-referrals. Of the 125 girls referred, 97% enrolled in the program. The majority of those who failed to enroll did this during the early part of the program before the full establishment of medical and educational facilities. Four of the girls were 12 or 13, 22 were 14-15, 66 were 16-17, 24 were 18-19, and 2 were 20 years of age. In only 26% of the cases were the girls living with both parents. 53% of the parents had separated and in 15% of the cases one of the parents was deceased. Although the majority of the girls enrolled did so with the first pregnancy, 21% of the girls had already had a prior pregnancy, with three having been pregnany two times in the past. More than 85% of the girls had received partial or full support from the Department of Welfare.

The social background of the girls requires some further comment. There have been significant factors appearing in a large number of the girls' case histories which have begun to establish patterns of problem areas. A large number of the girls referred have had an early history of repeated unexplained absences from school. Often this history stems from the age of 10 or under. Many of the girls have had a truancy record, and a number have already been adjudged delinquent. Of the 67 girls acknowledging church affiliations, 70% were inactive or not attending church at all at the time of their referral. 64 of the girls freely discussed prior sexual experiences. Of

this group 73% had sexual experiences for two or more years prior to the pregnancy. The history of early sex experience and lack of interest in school is significant in view of the repeated absences and later truancy. This pattern, coupled with the poor housing environment, should alert the community or should be an indication of preventive social education and leisure time activities for the preteen girls, especially those in slum areas.

The following problem areas observed by the social work staff are incomplete but represent a large enough number of the enrolled students to be significant. Several of the girls have appeared to be of low intellectual capacity with some degree of emotional instability of mental retardation. Frequently these girls appeared unable or unwilling to protect themselves from the males in and around their household. When these factors were combined, as they often were, with high population density in the area of residence, poor relationship with parents, particularly the mother and/or stepfather, a continuous pattern of adolescent pregnancies by other siblings in the family, and a lack of understanding or interest in the client's problems by one or both her parents, obviously the stage was being set for the present pregnancy. In addition, there was frequently an inability to participate in meaningful leisure time activity. There was little or no knowledge of meaningful activity for individuals or family groups. Frequently the girls demonstrated hostility towards one or both

parents. As has already been mentioned, there was an early disinterest in school. As one reviews this data, there is the increasing feeling of the need for community resources to screen and work with the adolescents and preadolescents who are in need of early supportive care which may prevent one or more of the pregnancies experienced by these girls.

The 125 girls referred to the program during its first year have been from the City of Syracuse and Onondaga County. Of some note, each of the 62 census tracts within the City of Syracuse has had at least one girl referred to the program. However, more than 50% of the girls come from 9 of the census tracts which are located in the lowest socioeconomic areas. When the girls have come from other census tracts, they generally have been from the lower socioeconomic families within these areas. This, of course, would be expected since the more mobile middle class girl would be the one more likely to try to conceal (even abort) the pregnancy. The large majority of the girls have become identified wih the Y-MED Program. For that large majority the program has been geared in curriculum to maintain the interest and continuous education, counselling, and medical care. Of considerable significance has been the interest of the girls in maintaining affiliation with the program and working with the social workers even after returning to the public school system. As the program has progressed, in addition to the already mentioned recognition of the need to detect problem girls prior to

pregnancy, there has been an awareness of the obvious need for supporting services for the infant of those adolescents who will be keeping their babies. The program has also recognized and is trying to answer the need of an agressive new type of approach by the community for finding foster homes and adoptive homes for infants of girls who want to and need to surrender for adoption. Further, it would appear that there is a need for a type of foster home which could accept both the mother and infant for supportive guidance and help when conditions indicate that the girl is ill-advised to return to her home after thetermination of the pregnancy and yet where adoption does not appear desirable or appropriate to the mother. All of these are now areas which are being actively explored with hopes for possible future solution.

EDUCATIONAL PROGRAM

The educational program of the Y-MED Center has been faced with the problem of the "high risk" student in a magnitude comparable to the problems already mentioned within the medical and social work programs. By nature of the previously mentioned factors which constitute a bias in population selection, the girls who enter the Y-MED Program are often the girls with the most complex educational problems. Pakter (1961a) found that two-thirds of the girls of school age who were pregnant had I.Q.s below 90 and one-third had

I.Q. s below 75. It is important to note, at this point, however, that the I.Q. of such a study, while reflecting educational difficulty, cannot be used as an adequate criteria of the girls' intellectual capacity. Girls from slum families, with little parental support and low educational motivation, will score lowest on the I.Q. tests, with scores often being unrelated to true educability. However, I.Q. measurements as reported would inversely correlate with the case of educability faced by the school system. The problems of the educator are further complicated by the variability within the group. Although the bulk of the girls may have had low I.Q. testing and prior school difficulty, a significant number of girls would still represent average educational achievers with desires for future education. Several of the programs already in existence have coped with the problem on the high achiever, or else by having an extremely limited educational facility. Within the Y-HED Program such a concept has been untenable. The feeling educationally has been that all girls should achieve the maximum education of which they are capable. Further, in addition to the educational opportunities, schools do represent an avenue for transmitting society's standards to the student. Therefore, the achievement of the educational program must also be judged by its ability to help the girls become useful and productive citizens within the society at large.

New York State law dictates that a girl attending school, who is known to be pregnant, may remain in school until such time as her condition becomes observable to others, or in the judgment of the school staff, is detrimental to the pupil or to the morale of other students. In either case, the decision is left to the discretion of the principal as to when exemption is requested. Educationally, in spite of home bound programs, the girl who does leave school due to pregnancy usually becomes a dropout. When there is no plan for adoption of the infant, a period one to two years can pass before the girl can re-enter school. Consequently, these girls fall far behind in school work, and especially if motivation has previously been poor, a high percentage of the girls never return for further formal education. Thus, obvious need can be seen -- that of preventing the girl from falling behind in her class work, of giving her every opportunity to progress at the same rate as if she were not pregnant, and of allowing her to achieve her maximum potential educationally and socially. These are needs which the Y-HED Education program has been attempting to solve, and they are ones which have been largely neglected in the past.

The program is set up to raise the education of the girls in several areas. It offers continuous instruction in the academic areas for those operating on a grade level. Basic education is offered for those functioning below their grade level. Office and business instruction in nonacademic areas

are presented as options for all, and are encouraged, especially for those who do not desire a traditional academic program. An attempt is made to develop salable skills for the nonreturners by providing information and basic skills for the world of work and by providing assistance into relationships with other existing agencies within the community. For those planning to continue education, attempts are made to provide preparation for re-entry into school by giving intensive guidance to the girls while they are in the program and also by encouraging the girls to later return for individual sessions with the staff and for group discussions with other girls facing the same problems.

One of the major problems encountered in he educational program is worthy of sharing. Almost 90% of the girls have been operating below grade level with approximately 3-5% entering from institutions for the mentally retarded. Only 10% are operating on grade level or abovd. Over 50% have had attendance problems prior to entering school and approximately 15-25% have had difficulties with school authorities. The school backgrounds of the girls have ranged from 7th to 12th grade. However, most are deficient in basic skills and are behind in their actual achievement level. Many of the girls, in spite of having passed 9 to 10 grades within the school system, are barely able to read and write their names. With the aid of a team planning unit the educational area has been organized to teach the subjects in two separate groups.

One group has concentrated upon junior highschool girls and the other upon senior highschool achievers. Further, within each group, by necessity, the girls have been broken down into what would constitute tutorial type of teaching. Where groups show deficiencies or needs in one area, the teacher can work with a group of six or seven students. Such areas include basic English skills, reading, writing, and speech difficulties since many of the girls have had basic problems in communication. Where more individualized areas of needs occur, the teachers divide the groups still further and often work with the girls on a one to one basis. For example, some of the girls will be working on French III, American History, or Social Studies, while other girls will be working on basic reading skills. While one girl was preparing to pass the regents in French, another was learning the alphabet and the most fundamental skills. Obviously, the educational problems have been complex. The only alternative would have been to exclude girls who were under achievers - or the contrary, which would have been equally unacceptable, to exclude theachievers. The Y-HED Program has refused to do either. Again, this decision would appear to demonstrate the program's uniqueness. Although the problems have been complex, and at times almost overwhelming, this very individualized approach to education seems to be meeting the needs of the individual girls. One of the encouraging signs is the growing number of girls evoking an interest in returning to school or demonstrating a desire to continue their education in some form.

PSYCHOLOGICAL SERVICES

Previous sections of the paper have dealt with medical, educational and social problems of the teenage pregnant female as being those of a high-risk nature. The psychological aspects of the Y-MED Program can be approached as being high risk from a two-fold point of view. The first would be the psychological problems of the patient herself which are of major complexity. The second would be the issues which arise in evolving a program which can have a chance of fulfilling the goals already presented in the paper.

A psychological problems which are encountered in attempting to adequately care for these girls are considerable. One is dealing with the problem of a group of girls who have been exposed to deprivation in some or all areas of development -- deprivation, at least, from middle class standards. The girls have been under achievers educationally, truants, and often delinquents from society's point of view. Parents, where existent, have provided weak and confused standards. Often the structure of the family has been shaky, and the girls have been subjected to conditions of overcrowding and social interaction of a far different variety than that known to middle class peers. Motivation, expectations, and aspirations are indeed very different. Ability to relate to possibly helpful authority figures is complicated by mistrust and previous experiences which have portrayed authority figures as not always being desirable of confidence. In addition, within the

group individualgirls can be expected to have varying problems, often of major significance. The role of the psychological services, from the point of view of the girls, therefore, must be extensive.

In addition to the psychotherapeutic function for an obviously high risk class of girls, there is the other area raised - that of the complexity of evolving not only a program with the ideals and goals of the Y-WED Program but a program which can effectively meet some of the goals. The possibilities of such effective results, focus on the group known as the staff - physicians, educators, psychologists, social workers, teachers, and nurses, and sometimes various other types of personnel involved in a program. Although the people administering a program may be dedicated to the enhancement of the social, emotional, intellectual, educational, and physical development of the girls, their abilities to communicate and relate effectively are of major importance in the success or failure of the program. It, therefore, seems appropriate to briefly report on some of the difficulties encountered by the program in its growth towards maturity.

It has been the hope that through a respectful orientation of the girls, (i.e. acceptance of them and their values at any point in time, and exposure to alternatives as well) that the possibility for identification wth new models is enhanced with resulting positive behavioral changes in all areas of development. The key phase in the above statement

is "a respectful orientation to the girls." This is difficult for it means that all the members of the staff have to have insight, not only into the behavior of the girls, but into their own behavior as well. Unless this is done, none of the members of the staff can really give to the girls, but instead will use thegirls to enhance their status and position, or, put more generally, to satisfy their own needs.

The psychiatric program at the Y-MED Center, therefore, also exists to escalate the communication possibilities between the staff and the girls. This can be done in part by providing a variety of services such as consultations on "problem girls", psychological testing when necessary, direct psychotherapeutic intervention, or the development of referral machinery for such possibilities. All this helps the staff understand the girls, but this is not enough. The staff has to understand itself - each peson has to be self conscious, each has to always ask "what do I want and why do I want it?' Unless each staff person can be sensitive to himself, the possibility of being sensitive tothe girls' needs is seriously limited. To meet these needs the staff attempts to provide frequent, open, and nondefensive communication. People are thoughtful and affectful. Each staff member is responsible to every other. No one is or should be outside the realm of praise for a task well done, on one hand, or of critical orientation to an incident of insensitivity on the other. Some of the psychological interreactions come out of staff meetings that are

held at the Y-MED Center twice weekly. But some of the most significant information has been gathered by paying special attention to what might be called the "grapevine" - passing comments at lunch, in the halls, discussions, after hours and the like. This is to be expected since there are always some discrepancies between the appearance (the rather formal situations in conferences) and the reality (the wider matrix of ongoing events and experiences) which often goes unmarked in the press of time, immediate crises, and the tendency in any program to stress the group at the expense of the individuals in it.

Communications between persons takes place in a variety of ways, only one of which is through spoken words. The actual words said may be very different from what is communicated. The content of the message the listener receives depends on both the speaker and the hearer. The speaker combines words with the tone of voice, inflection, gestures, facial expressions, bodily actions, and general attitudes. The hearer must interpret the spoken words in as many of these modes of communications as he can grasp. For example, a nurse may say to a teacher, "whenever you have any trouble, let me know and I will help you". The teacher may be getting two messages at this point, the explicit message, and another, which is, "if you need to send for me, you are ineffectual and weak". True, she may be misinterpreting the nurse, but in this instance reaction to the statement may determine the teacher's course of action.

Further, the statement itself may have additional meanings. If the teacher accepts the nurse's explicit message, the nurse may take over during an argument between two or three of the girls. The problem between the girls may be solved, but the nurse may be transmitting her authority to the girls and downgrading the teacher. Over a period of time, similar events may block out the possibility of helpful assistance by the teacher. Her confusion and frustration may decrease her effectiveness and sensitivity. Without her realizing it, in order to ward off perceptions of herself as helpless and impotent, she becomes more rigid in her actions with the girls. In the process the relationship needed by the girls may be lost. The girls may be thrust back into a familiar pattern. Their family lives have been marked by a lack of clear and meaningful communication with their parents, and their substitute for that has been a distinct subsystem among siblings. If the teacher has to retreat from a warm and effective relationship with the girls, they draw back to the more familiar system which has operated in their lives to the present time.

In the Y-MED Center when fruitful relationships between teacher and adolescent, physician and adolescent, social worker and adolescent, or other authority figure and adolescent have broken down, the adolescent needs often by result become secondary. The authority figures are usually unaware that their ineffectiveness is directly proportional to the difficulties they are experiencing. In the staff meetings, issues

such as these are repeatedly brought up. Difficulties in communication between one professional member and another are probed. Attempts are made to explore conflicts between staff members, to iron out interpretations of individual roles and sensitivity, and to share knowledge about observed aspects of girls' behavior with one another. People are not spared interpretations of ineffectiveness. Consultants are encouraged to work more closely with the girls. Roles are often redefined. Although on a day-to-day basis feelings of discouragement may occur, there has been a gradual picture of a sensitive and dedicated staff ironing out their own problems and slowly taking the steps which make them more effective as administrators, teachers, social workers, and clinicians. Thus, what may in actuality be described as a staff group therapy, appears to have positive bonus allowing more effective overall care for the individual girls.

DISCUSSIONS AND CONCLUSIONS

The preceding sections of the paper have attempted to review the problems of the adolescent mother, especially the adolescent mother from lower socioeconomic areas. Further, an attempt has been made to adescrib at least in part the operations, goals and beginning achievements of a program designed to answer some of these needs. The Y-MED Program, sponsored by Syracuse and Onondaga County, would appear to be unique among programs throughout the country. In operation

since November, 1965, it has attempted on an integrated basis to meet the medical, social, educational, and psychological problems of teenage pregnant females in a comprehensive manner. Recognizing that in these girls pregnancy cannot be separated from the total life situation, the program has attempted to offer all services under one roof. No girl has been turned away regardless of the complexity of her educational, intellectual, social and psychological backgrounds.

Because of the complex problems presented by the girls, each part of the program has invovated experimental approaches to patient service. The medical aspects of the program have encouraged individual doctor-patient relationships, with the patient knowing her doctor over a period of time and with her realizing that he will be present at the time of delivery. Appointments have been encouraged. Long clinic-type waits have been eliminated. To date, a large review is impossible because of the short duration of the program. However, important meaningful relationships have developed between the girls and the staff; and up to the time of writing this article, as has been mentioned, not a single perinatal mortality has been noted.

Socially, at times the problems have been staggering. Overcrowding of the homes, inadequate parent-child relationships, familial patterns of instability, and transient males drifting in and out of the homes have been but a few of theproblems. Planning baby care has required a multifaceted approach. Effor s

have been begun to create avenues for adoption and foster home placement, whereas few had been previously available. A large nursery has been where infants may receive care while their mothers attend school in order to continue education. Further, techniques of child rearing have become an important part of the overall program. A major attempt is being made to give the infants stimulation in the nursery and to teach the mothers patterns of infant care which will allow greater possibilities for the children to succeed in life. Educationally, because of the aim of the program to exclude no girl, a great deal of flexibility has been necessary. Education has been promoted on multiple levels. A program most closely resembling tutoring has been set up. Girls who function as seniors in highschool have been taught at the same time as girls who are at a first grade level. The goals have been established on an individual basis. For some, highschool graduation and subsequent college education are possibilities. Even for the low achiever, however, the possibilities of learning skills which may be of benefit in later life are significant. One of the signs of major achievement has been the relatively consistent attendance by girls who, previously in regular school systems, had marked problems of truancy and delinquency. Girls have appeared to identify with the program. Following delivery one of the frequent comments has been, "when can I return to school?"

From a psycholigical point of view, the problem has been two-fold -- treating the girls and at the same time helping the staff to solve some of the difficult problems which even sensitive individuals face in attempting to begin such a program. Individual girls have needed urgent consultation and therapy. But one of the major services has been the constant seeking to interpret feelings and philosophies which could in any way influence the program and the individual girls.

Obviously, after only one year the program is too young to assess. Yet at the same time, it would appear that the results are showing an exciting trend. If the apparent present prevention of infant problems continues, the possibility of eliminating some of the future problems within the children for the community and school systems five years off may indeed be a reality. With the individual girls, themselves, it would appear that strides have been made. The acceptance by the girls of the personnal, and in turn the medical, educational, and social programs, has been most gratifying. It would appear a high risk group from every conceivable point of view, is making strides which can perhaps result in steps to re-enter the community as more useful and productive citizens - as well as being citizens with a chance to enjoy life in a more meaningful way. As further results become available, the findings will be shared.

Proposal per B-1. YMED

A. Title: Special programs for inner city children

B. General Description: The type and number of staff members to be used are included in item 11. The program is designed to meet several of the more pressing needs of and problems faced by inner city children.

1. YMED

The project is designed to meet the educational, social, vocational and medical examination needs of the pregnant school age girl. Any medical treatment will be given the girls through their own physicians, by the Upstate Medical Center Clinic or by the Welfare physicians. School age girls who become pregnant are excluded from school. As a result, they either fall behind in their school work or they drop out of school.

This project is designed to meet the needs of this population, a population that has largely been neglected as far as education has been concerned.

OBJECTIVES OF THE PROJECT

a. To continue the education of the school-age pregnant girl

To offer instruction in the academic area for those who are working on grade level

To offer basic education for those that are functioning below grade level but near their potential

To offer some vocational education i.e. typing etc.

To offer instruction in Home Economics and Child Care

b. To provide medical services for the girl with the following objectives:

To decrease the high rate of infant and maternal death rates among this population

To decrease the incidence of malformation among the new born of this population.

To decrease the incidence of emotional disturbance found in both the young mothers and the infants in this population

c. To provide counseling so that:

The young mothers can make a decision as to the future of their children

The rate of recidivism is reduced

The young mothers will be more able to understand and cope with the problems associated with their condition

The young mothers can gather together the pieces of their shattered lives and start anew.

OD 005 689 - Attachment

PROCEDURE

a. The program is designed to reach the disadvantaged girl who has been excluded from school because of pregnancy. The deprived pregnant school age girl has up until now no way to continue her education or to get the help that the middle and upper class pregnant girl finds available in our society. Many of the deprived girls get little or no medical care or counseling until the birth of the baby. All of this results in social chaos with high rates of infant and maternal illness and death. Further the rates of reoccurrence among this population is high.

The program has a threefold objective:

(1) to aid in the further education of the girls

(2) to provide medical care for the girls and babies

(3) to provide guidance and counseling for the girls and their parents.

Instruction in English, Social Studies, Home Economics, Office Practice and Health will be offered on a full time basis. Art, Music, Physical Education and special courses (Math, Physics, Chemistry, etc.) will be offered on a part-time basis. Classrooms for these activities have been set aside in Washington Irving Elementary School.

A clinic that will be staffed by the Upstate Medical Center personnel will be opened in the school so that medical examinations and services can be easily and efficiently given.

A close working relationship with the home and with other agencies concerned with the girls problem (both public and private) will be instituted by the social work component. It will be the duty of this component to also work with the various schools that the girls came from in order that their schooling may continue.

The prenatal and post partum clinics will not be involved with medical care but will be used only for examination purposes. Medical care will be supplied by other agencies in the community. The infant care also will be concerned only with medical examination of the children and the education of the young mothers in child care and in acceptable practices concerning the rearing of infants.

Seventeen (17) teachers, elementary and junior high school, four (4) counselors and one (1) visiting were used extensively to reduce class size and supplement the guidance program.

Three (3) art teachers, five (5) music teachers and six (6) physical education teachers were used to introduce these various subjects in the K - 3 area.

The resource and materials center which revolved around our A-V division placed televisions, film strips and motion pictures and other A-V materials and equipment in the various Title I schools and supplied a film librarian, graphic artist and A-V aides to help teachers develop A-V materials and devices.

A total of 49 teacher-aides and secretaries were placed in the various schools to relieve the teachers and administration of routine matters and permit the professional personnel more time for concentrated personal effort with individuals needing their help in the varying degrees.

The Aladdin's Lamp Cultural Enrichment program provided a vast and varied program of cultural activities which reached 2400 students throughout its school year. One (1) coordinator was used in this area.

The Young Mothers Educational Development (YMED) Program employed three (3) teachers, a director, two (2) case workers and a clerk.

Three (3) teachers and three (3) teacher-aides were used to staff the Bishop Foery clinic of St. Joseph's Hospital, Elmcrest and the House of Providence. This program aided the excluded emotionally disturbed children.

The physically handicapped Junior High School student was serviced by two psychiatric social workers. This program enjoyed a visit from the Title VI personnel from Albany.

The Teacher Planning Program involved one (1) coordinator, eight (8) instructional specialist and three (3) regular classroom teachers who acted as relief teachers.

The Corrective Reading Program was made up of one (1) coordinator, ten (10) reading teachers and one speech teacher.

Seven (7) Guidance counselors, six (6) visiting teachers and four (4) psychologists were used to supplement the guidance personnel and introduce guidance services on the elementary level.

Special trained teachers were used in a program designed to handle re-entry of school drop-outs at the various levels.

Evaluation copy #1

Evaluation sheets are filled out by the pupils and teachers upon completion of these trips. An analysis of the evaluation sheets point out time and time again the value of such a program.

(N) EXEMPLARY AND / OR INNOVATIVE PROCEDURES

Pre-planning as well as follow-up for the field trips are probably two key activities which are effective in reaching the objectives of this program. Many times in the past a field trip was in reality a "bus ride" with no planning or follow up activities. "Bus rides" have been discouraged but worthwhile field trips are heartily encouraged.

One field trip activity which, we believe, may be innovative is our so called "Tour of Syracuse" field trip. This particular trip involves a full day tour of the city and familiarizes the student with historical, recreational, cultural economic level neighborhoods and ethnic and racial areas of Syracuse,. Many class discussions and projects have resulted from this particular field trip.

C - SPECIAL PROGRAMS FOR INNER-CITY CHILDREN

C-1 PRENATAL AND POSTNATAL PROGRAM

Evaluation copy #2

This is a continuing program for school age pregnant girls during their prenatal and postnatal period. It is designed to meet the educational, social, vocational and medical examination needs of the pregnant school age girl. All medical treatment must be given through the girl's own physician or cooperating clinics. As pregnant girls are excluded from school, they either fall behind in their school work, or drop out of school. This project is designed to meet the needs of this population as far as education has been concerned. The objectives of this project are to continue the education of the school-age pregnant girl, to offer instruction in the academic area for those who are working on grade level, to offer basic education to those functioning below grade level to offer some vocational education, instruction in home economics and child care, to provide medical services for the girl with an eye toward decreasing the high rate of infant and maternal death rate, to decrease the incidence of emotional disturbance found in both young mother and the infant.

Counseling will help young mothers decide as to the future of their children, reduce the rate of recidivism, permit the mothers to be more able to understand and cope with the problems associated with their condition and help gather together the pieces of their shattered lives and begin anew.

A co-ordinator, three (3) teachers, one (1) stenographer, and two (2) case workers are employed in this particular program. Consultant services as well as the necessary supplies and equipment to implement the program are purchased within the budget allotment of this project.

The local Welfare Department, Health Department, and YWCA supply personnel and services to this program.

(B) EXEMPLARY AND / OR INNOVATIVE PROCEDURES

One procedure that has been quite effective in reaching the objectives of this program is that of individualizing instruction as much as is possible. Since the girls enter the program from a wide range of grade levels it is imperative that the program be individualized as much as is possible and this has been done.

One innovative feature might be pointed out is the new intake - form employed by the case workers. This particular form is designed to deal with the students in depth. The form insures that the student's records are complete and comprehensive. The form is designed to schedule the girl for individualized subject work and counseling services.

Follow-up work is being done on every girl who was or presently is - a participant in the program.

An interesting follow-up report concerning the 1966-67 school year points out the following information.

Of 93 girls in the program this year, thirty-three (33) have left the program. Of these ten (10) returned to school, eight (8) received their high school diplomas, four (4) entered work training programs, one (1) married, eight (8) are at home with their child and one (1) is attending night school.

An innovative procedure such as intake forms enables us to better measure the effectiveness of the program.

C-2 THE EXCLUDED EMOTIONALLY DISTURBED CHILD

This project is designed for emotionally disturbed children who have been excluded from school attendance. Some of these children can live at home, but others are residential students and are housed and cared for at the House of Providence and Elmcrest. The addition of educational services through a special educator will enhance the psychiatric and psychological treatment these children are now receiving. The chief objective of this program is to permit these disturbed children to resume their education, once their emotional problems have been corrected, at a level commensurate with their age and maturity.

Three (3) special education teachers are employed in this particular program. Instructional supplies as well as equipment are purchased with funds provided for this program.

Weekly staff meetings, special education in service training meetings, and meetings with individual teachers are three of the precedures used to achieve the goals of this program.

f) Teachers were given much assistance with the clerical and housekeeping duties. The principals found the aides and secretaries to be of great help. This is indicated by the requests from both groups for more aides.

field trip program

g) Inner-city children were taken to historical and cultural sites both within and without the city.

h) The trips were integrated with the curriculum so that they were meaningful.

2. Project Title: Special Programs for Inner-city Children

YMED

a) The education of pregnant teenage school girls was continued - enabling a number of girls to graduate and most of the others to return to school. (see report)

b) Medical services of the highest quality was given to the girls.

c) Counseling was given the girls by psychiatrists and psychologists from the Upstate Medical Center.

excluded emotionally disturbed child

d) This program provided instruction in the basic disciplines for children who were so emotionally disturbed that they could not be contained in the normal school setting. These children responded to their teachers but in most cases were so emotionally disturbed that they did not return to their classes in their regular public or non-public school.

hot lunch

e) The program provided a nutritionally balanced lunch for all children from the lower income areas bussed to outlying schools and for all the children in the inner-city schools who wished to participate. In general, the program was well received - perhaps more so from the perspective of the parents and the children than the teachers and the principals. The latter were used to having long free lunch periods and the inception of the lunch program ended this.

physically handicapped Jr. High student

f) Counseling of the handicapped child, the child's parents and teachers was carried on by the psychiatric social workers. This is an area in which evaluation is very difficult but from the reports from the parents and children it seems to indicate that these two professionals met a real need.

3. Project Title: The Continuation of O.E.O. In-school Programs

a) The teacher planning program offered the following:

1. Released time to work and plan together with qualified assistance from specialists in a variety of disciplines.

2. A way of using the strengths of team members as a common resource to the other teachers.